LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into Annual and Financial Reports 2022–2023)

Members:

MR J MILLIGAN (Chair)
MR M PETTERSSON (Deputy Chair)

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 21 NOVEMBER 2023

Secretary to the committee:
Ms K Langham (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

APPEARANCES

ACT Health Directorate **127**
Canberra Health Services **127**

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 1.04 pm.

Appearances:

Davidson, Ms Emma, Assistant Minister for Families and Community Services, Minister for Disability, Minister for Justice Health, Minister for Mental Health, Minister for Veterans and Seniors

ACT Health Directorate
Moore, Dr Elizabeth, Coordinator-General, Mental Health and Wellbeing
Garrett, Ms Cheryl, Executive Branch Manager, Mental Health and Suicide Prevention Division
Arya, Dr Dinesh, Chief Psychiatrist, Office of the Chief Psychiatrist

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
McKenzie, Ms Katie, Executive Director, Mental Health, Justice Health & Alcohol and Drug Services

THE CHAIR: Good afternoon and welcome back to this public hearing on the Health and Community Wellbeing Committee for its inquiry into annual and financial reports for 2022-2023. The committee will today examine the annual reports of the ACT Health Directorate and Canberra Health Services.

The committee wishes to acknowledge the traditional custodians of the land that we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's hearings.

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses use the words, "I will take that as a question on notice," or words to that effect. This will help the committee and witnesses to confirm questions taken on notice from the transcript.

We welcome Ms Emma Davidson, Minister for Mental Health and Minister for Justice, and the officials today. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw their attention to that privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Please confirm that you understand the implications of the statement and that you agree to comply with them. We could do a consensus around the table now, if you want to do that, or when you speak. Visiting officials, when you come to the table, agree to the pink statement. Do you all agree?

Witnesses: Yes.

THE CHAIR: As we are not accepting opening statements, we will proceed with questions. We will work our way down the table. My question is about the *Office for*

Mental Health and Wellbeing work plan. The original work plan for the office was a three-year strategic plan established under the previous minister, following the commencement of the office. That plan expired in 2021. The new work plan was not launched until June this year, so the question is: why was there an 18-month gap between work plans?

Ms Davidson: There has been quite a lot happening within public health over 2021 and 2022 and prioritising the needs was the right thing to do at that time. I will pass to Dr Elizabeth Moore who can talk more about the process that we have gone through to reach a new work plan and what kinds of consultation and engagement we had to do that.

Dr Moore: Thank you, Minister. My apologies for not being there in person. I have read and acknowledge the witness statement. Something called COVID happened and we decided, with our work plan, that, because we had been unable to complete some of the actions in our original work plan, we would approach the minister to see if we could delay the setting of a new work plan in order to be able to complete the actions in the other work plan. This was agreed to as it was very sensible, and then we went forward with our next work plan, which is a one-year work plan. It is only for one year because we were going to do the Office for Mental Health and Wellbeing evaluation, which is currently underway and is nearly completed.

The Office for Mental Health and Wellbeing has been in place for five years. There was a mid-term plan and a mid-term evaluation, but there was always going to be an end-of-term evaluation, and that is the one that is currently underway with KPMG and is almost complete.

The 18-month gap was because of a number of factors, including COVID, the need to be pragmatic and completely actioned in the first work plan before going forward to the next work plan, and also the need to have thorough consultation around what needed to be in the next work plan, which is a mixture of continuation of projects that are already underway and a deep dive into things such as the needs of the community, this multicultural—

THE CHAIR: Minister, when did the work commence on this new plan? If we refer to the original plan, were there any works that were not completed in the original plan?

Ms Davidson: I think Dr Moore can answer those questions in more detail about when the work started on the new plan and when the work was completed on the previous one. I should also note, though, that our health workforce in the ACT, including our highly skilled policy workers and the people in the Office for Mental Health and Wellbeing, have done an enormous amount of work over the last few years to deal with some really unprecedented health crises that our community has been facing. I do not think that this city would be in the position that it is in today, in terms of people's health and wellbeing, without all of the efforts of everyone who had been involved in that. As a community, we should be really thankful for the work that was done to try to protect people's health and wellbeing during the pandemic. Dr Moore can talk about when the work started for the new plan and when the previous one was completed.

Dr Moore: Thank you, Minister. The one major piece that we were unable to complete to my satisfaction from the old work plan was around the mental health promotion and prevention plan. Part of that is that we have a number of values in the office and one is around neuroduplication, and we knew that the second prevention plan was also coming and we wanted to get mental health included in that plan.

Having said that, we are in negotiations with Prevention, Mental Health Australia. We have done a number of plans for different states and territories and we feel that they have much to offer us. They are unable to undertake a piece of work for us this year, but we are hoping that they are able to—I am part of the Prevention Mental Health Conference next year—undertake some work for us. They have a significant piece of work that was done both in Victoria and in Western Australia.

In terms of the work plan for the coming year, we have already started our consultations with the culturally and linguistically diverse community. I have done a number of podcasts and radio. There has been radio around mental health and wellbeing in the multicultural community. And we have, of course, been continuing to develop our workforce plan. The workforce strategy was approved by the minister. We are doing a piece of work that is currently under consideration in the government.

THE CHAIR: Are there any supplementaries? I will start with Mr Pettersson.

MR PETTERSSON: Thank you. With regard to the work plan, there is one section I am particularly curious about. It says the office has also advocated for peer workers since the establishment of the office. It goes on to talk about some of the benefits and that research has shown a wide range of benefits from increased peer work, including a reduced number of bed days, reduced admission rates and increased levels of empowerment. How many peer workers are currently employed by Canberra Health Services in clinical roles?

Ms Davidson: Before I pass to Katie McKenzie, who can talk more about the peer workers we already have in Canberra Health Services, it is really worth noting that we have a very diverse health services landscape in the ACT. It is not just at Canberra Health Services where you might find people in the workforce; also, community sector organisations deliver health services funded either by the Commonwealth or by the ACT government or through philanthropic funding, and private sector health services as well as primary care are primarily regulated and subsidised by commonwealth programs.

If you want to get a better understanding of the peer workforce in the ACT, you might direct some questions to the Office for Mental Health and Wellbeing, who have recently employed a director of lived experience and are working with a broader range of organisations that employ peer workers rather than solely focusing on Canberra Health Services. Katie McKenzie can talk a bit about what we are doing with peer workers in CHS.

Ms McKenzie: Thank you, Minister. We currently have three peer workers, although they are not termed “peer workers”, and a director of lived experience commenced in the last two months, so that makes four.

MR PETTERSSON: Do they interface with consumers?

Ms McKenzie: They do.

MR PETTERSSON: Thank you.

THE CHAIR: Mr Cocks.

MR COCKS: To start with, I want to build on that. We previously discussed the limited opportunities for peer worker training., I am very keen to find out whether there has been any progress made around improving access to training for peer workers in the ACT, and in particular at the CIT, which we have discussed before.

Ms Davidson: The fee-free training courses at CIT are continuing. It is a great opportunity for people who are looking to either start a career or make a career change to be able to get that qualification without having to pay the fees. I might pass to Dr Elizabeth Moore who can talk more about the work that the director of lived experience is doing within the Office for Mental Health and Wellbeing to support the development of our peer workforce.

Dr Moore: Thank you, Minister. We have a director of lived experience who has significant experience in developing the pipeline. We are interested in not only people being able to have the relevant qualifications for peer work but also the support for peer workers and the continued professional development of peer workers and their retention within the system. Mr Foxlewin is working with the director of lived experience at Canberra Health Services and with other major parts of the total mental health landscape to look for the best way of setting up, similar to a community of practice, a support network for peer work, as well as increasing the number of opportunities for people to gain peer or lived experience qualifications. We have had a number of scholarships that have been supported by the commonwealth and we are seeing if we can grow that area.

MR COCKS: Thank you. Back on the work plan, there seems to have been a fairly significant, if at times subtle, change in tone and approach under the work plan, starting from the very beginning, where there is no foreword from the minister. There seems to be no reference to improving coordination of drug treatment and mental health. Has there been a decision taken to remove that role from the office? If so, when did that happen and what was the reasoning?

Ms Davidson: The focus for the Office for Mental Health and Wellbeing, right from the very beginning, has been around early intervention and prevention—looking at what we can do to improve people's wellbeing and get them access to services as early as possible in their mental health journey. That continues to be a focus for the Office for Mental Health and Wellbeing in their work plan.

I can pass to Dr Moore who can talk more about where the shift in focus is. This is a relatively newly established office, still within the ACT government's public service. One of the things that the Office for Mental Health and Wellbeing has is the ability to talk across all the directorates. It is really important when you are talking about

prevention and early intervention to be able to address some of the social determinants of people's mental health and wellbeing.

MR COCKS: Absolutely, and that is why I am interested in the removal of that content.

Dr Moore: Mr Cocks, the removal of the content does not mean that we are not doing anything in this area. In fact, similar to our coordinating groups that we set up for youth services, we have been able to allocate some money to ATODA and the MHCC to drive a community of practice across drug and alcohol and mental health services. With a comorbidity of 70 per cent between mental health and drug and alcohol, it is part of our makeup that we would continue to do that. I am happy to talk you through more of what we are doing in that area.

MR COCKS: I would be more interested in the decision—why it has been, at the very least, de-emphasised in this work plan and effectively removed. That strategic direction matters in terms of ongoing work, as to where you prioritise your resources, which are clearly limited resources. Was there an explicit decision to remove that?

Ms Davidson: If you go back to the last estimates hearing, when we talked about the money that was allocated in the budget towards better integration of mental health and alcohol and other drug services, I think you will see that we are quite clearly resourcing work to be done around that area. That is ongoing—

MR COCKS: This is explicitly the Office for Mental Health and Wellbeing and its role in particular—just that decision point. Has it been an explicit decision?

Dr Moore: Mr Cocks, the Office for Mental Health and Wellbeing does not do everything. We will not duplicate; we will support. If we feel that somebody is managing well, we will support them to do that. I am sorry if you feel that it has been deliberate to not have that as a focus, as you say. We can only focus on certain things, if we feel that MHCC and ATODA can manage a coordination arrangement. We also have a piece of work that is happening through Mental Health Policy and Strategy. They are drafting a whole section of treatment of health—sorry, ACT Health. Then we will not have that as one of our first signs. We will make sure that it still occurs, though.

MR COCKS: It sounds like you are confident that it has been handled elsewhere, so you do not need to have that as a priority for your office.

Dr Moore: We will continue to monitor that in our landscape, as we always do.

MR PETTERSSON: Thank you. If a person is having a mental health crisis and they are also on no-call Access Mental Health, what happens next?

Ms Davidson: When someone is having a mental health crisis, there are a number of places where they might seek help. There might be a call made to PACER, for example. Police have been telling us that they have seen an increase in the number of people who have needed to have a PACER call-out. There has been an increase in the number of calls that are coming through to police for someone who is in crisis. This is

part of the reason why we have been investing in more services for PACER and more resources for that team.

People might also choose to go to Safe Haven where they can talk to peer workers about what they are experiencing and get some support there, or they might call Access Mental Health and need a visit from HAART. It depends on the person, what their needs are and where the call goes. There are a number of places that can be called if someone is in crisis.

MR PETTERSSON: Bear with me while I take a step back. People can call Access Mental Health and speak to someone who would get engaged with the situation and then potentially make a referral?

Ms Davidson: Yes. I might pass to Katie McKenzie who can talk some more about the referral process through Access Mental Health.

Ms McKenzie: When a person calls in crisis to access mental health—there are lots of reasons to call Access Mental Health and crisis is one of them—they are given a triage category from A to E, with A being immediate through to E, which is referral to a GP. There are lots of actions that can happen between those. As the minister said, it can range from PACER or police intervention through to advising the person that they need to come to the emergency department, through to recommending to the person that their care needs are best met through their general practitioner. It is a clinical point of contact and a clinical triage occurs in that phone call.

MR PETTERSSON: Wonderful. What is the relationship between Access Mental Health, PACER and HAART? Is information shared between these teams? And, if so, how?

Ms McKenzie: They are all one team. PACER and HAART have one team manager. They are one team; they share a roster. Access is part of the same program area within the MHJHADS. They too share a similar internal management and governance structure. They do share information. Access can make a referral to PACER or HAART. PACER can make a referral to HAART, and HAART can also make a referral to PACER. They are linked services and people move between those three services along a continuum, depending on what their care needs are.

MR PETTERSSON: Are there any instances where Access Mental Health, PACER or HAART might decide not to visit someone who is having a mental health crisis and has been assessed as needing support?

Ms McKenzie: They make the assessment. It is a clinical assessment. There is a level of expertise in making that assessment. There will be incidents where people are not visited because the clinical assessment has been that they do not need immediate intervention. A follow-up can come in many ways. It can be a referral to a community health team or a suggestion to go to a non-government organisation, or it can also be a suggestion to return to the GP. There will be incidents in which somebody is not immediately visited after calling Access.

MR PETTERSSON: For the people who are assessed as needing support, though,

are they always seen?

Ms McKenzie: Always. Category A is an immediate response.

MR PETTERSSON: How many staff are employed in these three areas? What is the breakdown of the team?

Ms McKenzie: I have that to hand. If you give me a moment, I will pull out the exact figures for you. Access Mental Health have a budgeted FTE of 25 and we currently employ 21.4. HAART and PACER—as I said, they are one team—have a budgeted FTE of 29 and we currently employ 23.8. Those figures are up to date as at October.

MR PETTERSSON: Cool. How many times in the last year have Access Mental Health, PACER and HAART been referred or engaged to provide support and have not been able to within four hours of receiving a referral?

Ms McKenzie: I am going to have to take that as a question on notice.

MR PETTERSSON: Fair enough.

Ms Davidson: There are going to be different reasons for the three teams. We have a second PACER team, but there are still going to be occasions when the team might be busy. A PACER call can take quite a while to complete. If another call happens to come through while the team is already busy with someone, then they may need to be seen by someone else, other than PACER.

Ms McKenzie: It is a clinical triage process, so, if somebody is determined to need immediate need, that is met. It is just about how long the time frames are behind that. I can take that as a question on notice and give you some detail.

MR PETTERSSON: That would be wonderful. I completely understand the points you have made. I am just trying to get a better understanding. If Access Mental Health, PACER or HAART visit someone during a crisis, are they under any obligation to check up on them after that visit?

Ms McKenzie: The experienced clinician makes the judgement about what is needed and will determine whether follow-up is needed. Sometimes follow-up does occur and sometimes the clinical judgement will be that follow-up is not needed. When we say "obligation", their obligation is informed by their clinical judgement.

MR PETTERSSON: Does that follow-up receive a classification as a priority?

Ms McKenzie: Every point of contact with our clinical service has a triage prioritisation. When Access refers to HAART, HAART then prioritise based on their current case load.

Ms Davidson: Having listened to Katie's answer earlier about where people might need to be seen, some people will have a regular healthcare provider and it might be appropriate for them to do the follow-up with the person who normally sees them and has their full and ongoing history and ongoing treatment plan.

MR PETTERSSON: That is essentially the answer to my next question. I will ask it anyway. Is there any instance where Access Mental Health, PACER or HAART would refuse to provide support when a referral is made, because a person is receiving support through a private service or through an advocacy organisation?

Ms McKenzie: I am happy to answer that.

Ms Davidson: An advocacy organisation is not going to provide the same clinical services as someone's normal healthcare provider. An advocacy organisation is very helpful with referrals and making sure people are connected to the right service, but you are still going to need a service provider to provide clinical services. That is what they do.

Ms McKenzie: They will not refuse to provide care because a private provider is involved. The clinical team in that space will make a judgement of immediate need and risk. If their judgment is that a need for a risk can be met by the private provider, they might recommend that the private provider's services be accessed.

MR PETTERSSON: Would that decision be made on the phone with Access Mental Health or would that be when, potentially, the PACER team sees someone?

Ms McKenzie: It can happen at any point of contact with our service where a judgement about need and risk is made.

Ms Davidson: It is also pretty important to try to maintain that continuity of care for a person to achieve the best health outcome. You do not want them to have to change providers frequently and end up with more fragmented care.

MR PETTERSSON: This is the last one from me. How often does Access Mental Health, PACER or HAART provide a referral for someone to ISRP? Is this something that happens often or never?

Ms McKenzie: I will have to take that question on notice too.

THE CHAIR: Mr Cocks, on a substantive.

MR COCKS: Thank you. Turning to the issue of admitted patients absconding from care, it was recently revealed by the ABC that 31 patients had absconded from mental health care in the last year. This information, as I understand it, was sourced from an FOI request. Could you tell me, just to start with: what is the source of that figure—31 patients? Is it related to FOI CHS FOI23-24.18?

Ms Davidson: You are asking where the information has come from that you have—

MR COCKS: The 31 patients that was reported—

Ms Davidson: or are you asking whether it is correct?

MR COCKS: The information that was reported by the ABC that says it has been

sourced from an FOI.

Ms Davidson: I could not tell you off the top of my head which FOI it would have come from, but we do get them from time to time. Sometimes they are from MLAs. We know that there are some people who have not returned from leave when they were expected to and not all of those would be considered as people who have absconded.

MR COCKS: The question is about the source of the figure—31 patients. Can anyone tell me where that comes from?

Ms Davidson: I might pass to Kate McKenzie who can talk about how many patients we are aware of that absconded in the 2022-23 financial year. I assume that is the figure that you are talking about.

MR COCKS: It is the figure that was reported by the ABC that said there were 31 patients.

Ms McKenzie: I am unable to comment on the exact FOI. I can tell you where the information comes from. It is a manual count from the inpatient areas that we collate, and the information for the FOI came from that manual collation of information.

MR COCKS: I think this is important because the FOI that I can find on the disclosure log says that it requested three different things, including correspondence between Canberra Health Services' officials regarding concerns about or requests for searches for elicit substances at Dhulwa by staff or police; information and correspondence regarding consumers who have failed to return to Dhulwa from leave and measures taken to find or return them; and information and correspondence regarding reportable incidents involving consumers at Dhulwa. The disclosure for this particular FOI, which seems to be relatively consistent with the reporting, contains no information on points 2 or 3. That is despite relevant information being reported in the media. Why does this disclosure not have that information?

Ms Davidson: Your question is about the details of an FOI disclosure that was made to ABC reporting?

MR COCKS: My question is about an FOI disclosure on the disclosure log, when we checked and followed up on the FOI disclosure. It seems that the decisionmaker has not released any information that is consistent with what we have read in the media. There is no reference to the number of patients who absconded. There is no information relating to reportable incidents involving consumers at Dhulwa. I am just trying to find out why there is a discrepancy between what is on the disclosure log and what is in the media?

Ms Davidson: Are you suggesting that perhaps some of the information in the media did not come from the FOI disclosure?

MR COCKS: I am interested in the media report saying that the source of the information was from the disclosure, and I would really like to understand why there is a difference between what has been disclosed in that log and what has been reported

in the media. Is it that there is no information? I would really like to understand what has happened here.

Ms Davidson: Where media get their information from if it is not the FOI disclosure that you are referring to might be a question that you could better address to the journalist that wrote the story, as to what their sources are.

MR COCKS: Are you suggesting that the ABC is not correct when they say they got the information from the FOI?

Mr Peffer: I might be able to add something. Generally, in my experience of how these media stories are put together is that some information might be sourced from an FOI and we will receive a series of follow-up questions about details that may or may not be included in the FOI, and we do our best to be transparent and helpful in responding to those queries. It could be the case—and I am not sure of the particulars; I do not have the requests around this story in front of me—that, if the information is not in the FOI, it is highly likely the ABC came to CHS and asked a series of questions through the minister's office and we responded to those questions. Regarding the numbers that you are referring to, if they are not in the FOI, we would have likely provided those numbers.

MR COCKS: Okay.

Ms Davidson: When you are referring to how many people have absconded, it is also really important to be clear about the difference between that and someone just not returning from a period leave at the exact time they were expected to return and what actually is classed as someone absconding and what is not. Sometimes what people think of as absconding, from a technical perspective, is not. It depends on—

MR COCKS: This should be information which has come from the government, according to the reporting. Perhaps, just to help us understand the extent of the problem, could you confirm the total number of individuals who absconded from care, how many did not return from leave and the total number of occasions—not individuals, but occasions—on which this occurred in the last financial year?

Ms Davidson: My understanding is that, for the financial year 2022-23, there were a total of 28 people receiving mental health care who were uncontactable during a period of approved leave, and two of those were under a section 309. I do not know if that helps you at all with the detail of what you are looking for.

MR COCKS: That is not the full answer.

Mr Peffer: Mr Cocks, the minister has spoken about a financial year, I believe. The calendar year figure that I have available is 31, which aligns with what you are asking about. If you are asking about the validity of the numbers, that does align with—

MR COCKS: Okay, so that is the number who were unaccountable during a period of leave?

Ms Davidson: Yes, but I would also like to point out that, for the financial year

figures that I was talking about, only two of those were people who were under a section 309 order.

MR COCKS: When patients have absconded or been uncontactable during a period of leave, as a proportion of the number of incidents, how often do they return voluntarily?

Ms Davidson: I might actually ask Dr Dinesh Arya to talk a bit more about what happens with leave and what the process is to make sure that we are keeping the person safe as well as the community. The primary concern quite often when someone is on therapeutic leave and is not returning exactly when they were expected to, is to make sure that we know where the person is and whether they are safe.

Dr Arya: I have read and acknowledge the privilege statement. Katie McKenzie may be able to describe the exact process that is followed at CHS. Whenever anyone has gone on leave and has not returned on time, the expectation is that the absconding management process begins. The staff at CHS are very clear on what process needs to be followed if someone has not returned from leave on time.

MR COCKS: Is someone able to provide information on how often patients return voluntarily? That was the question.

Mr Peffer: I think we would have to go back and look at the manual data around that.

MR COCKS: You can provide that on notice?

Mr Peffer: We can have a good go.

Ms Davidson: We can.

MR COCKS: When you do so, could you also perhaps let me know the average time a patient was missing after a absconding and what the longest time was that a patient was missing? Are you able to take those on notice or provide information on that?

Ms Davidson: An average might not actually provide the kinds of answers that you are really looking for if you are wanting to understand how often—

MR COCKS: I am still interested in it, Minister.

Ms Davidson: I am actually wondering if a bit of a range of how long someone might be not back from having returned from leave, might help you.

MR COCKS: I would be very comfortable if you wanted to break down the data into percentiles or in quintiles.

Ms Davidson: I guess what I am getting at is that there is a range of reasons why someone might not return from leave. Some of those might be as simple as they missed their bus and they have to wait for the next one. Then there will be other times where someone decides not to return from leave and it is because they have decided they wanted to go do something completely different and not come back to the health

facility. An average period of time will not necessarily give you an understanding of the range of reasons why someone might not return from leave when expected and how long they might be gone for.

MR COCKS: I understand there is a range of different reasons. With this question what I am interested in is in the actual length of time. That would be very useful.

Ms Davidson: If we can give you some information about the range of lengths of time that might be more useful than just a straight average.

MR COCKS: I would like an average as well and the longest time a patient was missing.

Ms Davidson: Okay.

MRS KIKKERT: Minister, you said that, of the number of people that absconded, only two of them are from section 309. Where are the others from?

Ms Davidson: I was talking about people who were uncontactable during a period of approved leave. I might ask Dr Arya if he would like to talk about the reasons that there is a difference between someone who is uncontactable who is a section 309 and other people who might be taking therapeutic leave.

Dr Arya: The other people would be people who are admitted to the inpatient unit. Some of those may be people who are on a compulsory treatment order or a mental health order. If they have been granted leave and they fail to return, then obviously the process would begin to try to contact them. I will not be able to give the exact numbers, but we can take that question on notice and try to provide that information.

MRS KIKKERT: Okay; great. Thank you.

MS CLAY: Minister, what is the culture like now at the Dhulwa Mental Health Unit?

Ms Davidson: It is actually substantially different from when the internal review processes started on Dhulwa with Barb Deegan as the independent chair of that process. There have been quite a lot of changes that have already been put in place. Those have been assessed by an independent governance board that includes representation from the ANMF, from Carers ACT, from consumer representatives and from CHS as well. I might pass to Kate McKenzie who can talk more about how different things are today compared to where they were, say, 18 months ago.

Ms McKenzie: As you know, the Dhulwa independent inquiry made 25 recommendations. Each of those recommendations had a number of sub-recommendations—so 53 actions in total. The team have been really committed to this period of reform. We have closed off 29 of 53 of those actions, and we have closed off seven full recommendations.

To answer your question directly about culture, we are eagerly awaiting the culture results. Last year, the culture results came through that they were not good for Dhulwa. This year there has been a really strong response rate from the Dhulwa team.

We have done some informal measures throughout the year to make sure that our reform program is effective. But they are not something that would directly translate to a culture measure. It is a range of measures that Best Practice Australia will be reporting imminently.

MS CLAY: Of those 29 actions that you have completed, what are those actions? What are the themes of those actions?

Ms McKenzie: There is an education plan for nursing, a therapy program, a trauma informed training approach and education on DASA, which is a risk assessment and aggression prevention tool. We have our new model of care out for consultation. That got sent out yesterday. We have had a series of workshops and consulted a number of people in the development of that document. There is a range of actions, including introduction of a primary nursing model and embedding of safe wards. I could go on and on. There are 29 pieces of work. There are a lot of things.

MS CLAY: Sure. What are the ones that you have not got to yet?

Ms McKenzie: We have to formalise our staffing profile. There will be a number of actions that will be closed off with the endorsement of this model of care, which will happen in January. Those that are not closed off yet relate to staffing profile, role of security and welcome book for consumers. We needed the model of care to do that. There are also a number of education packages that we are due to implement early next year. The program of reform is well on track, and we anticipate that all of the recommendations bar two will be closed in the 12-month period.

MS CLAY: Great.

Mr Peffer: I would also add that what is important for us is not just the effort going in and the time and investment, which is significant but also the impact. A key indicator for us and something that we are very proud of—and I am proud of the team as well—is that the last occupational violence incident reported at Dhulwa was October 2022, over 12 months ago.

MS CLAY: You anticipated my next question. I was going to ask how we were going with staff safety.

Mr Peffer: There you go.

MS CLAY: So no incidents since October 2022? So during the year in which these actions have been implemented, there have not been any other incidents of occupational violence?

Mr Peffer: A very strong turnaround.

MS CLAY: Are there any other sort of tangible measures—though that is probably the main one—and ways that you can tell if it is working.

Ms McKenzie: One of the actions outstanding is the use of a therapeutic tool called EssenCES. It is actually how forensic health units measure that they are operating in a

therapeutic environment. EssenCES is actually being implemented at the moment and we will have an outcome from EssenCES at about the same time that we have the culture score. We are looking forward to being able to triangulate lots of pieces of information in January to February and present those to the Independent Oversight Board.

Ms Davidson: For me, one of the really important things has been hearing the change in how people who are working in that environment feel about going to work every day. When you are talking about how we support a healthy, resilient health workforce, one of the things that mental health nurses talk about is wanting to be able to practise to the top of their scope of what they have been trained to do and to feel engaged in making sure that they are delivering the best quality care to their patients. It is something that really care about, particularly for something as complex as forensic mental health care. These are mental health nurses for whom it is a real vocation to provide that kind of care to people. They are feeling a lot better about going to work than they were a year and a half ago, based on the feedback that I am hearing.

MRS KIKKERT: You mentioned the role of security. This is just a yes or no answer, please. Are security guards now allowed to interfere between a staff and a patient during an incident of physical violence before the buzzer is pressed for the manager to actually come on board? Are they allowed to interfere now before that buzzer is pressed or not?

Ms McKenzie: No.

MRS KIKKERT: They are still not allowed to do that?

Ms McKenzie: There is no need for them. The role of security is perimeter. The role of their clinical team is managing those interpersonal dynamics that happen on the ward. That would show that the team are actually managing them very well.

MRS KIKKERT: So, if a security guard or any guard witnesses physical violence between a patient and a nurse, they are not allowed to interfere unless they actually press the button first before a manager comes on board? Is that correct?

Ms McKenzie: It would be a clinical response.

MRS KIKKERT: A clinical response?

Ms McKenzie: A clinically led response.

MRS KIKKERT: So he still cannot interfere and stop the violence from happening?

Ms McKenzie: That has not changed and there have been no incidents of violence.

MRS KIKKERT: So it has not changed. Thank you.

Ms Davidson: One of the really important things that we were just talking about is that, with all of the changes that have been put in place, we have not had incidents of occupational violence since October 2022 in that environment. Nurses are feeling that

they are able to go to work and practise to the top of their training skills, and that includes all of the training that they do in relation to security and providing therapeutic care to people. That is a really key part of making a safer environment and helping them to be supported to do their jobs well.

MR COCKS: If there have been no incidents of violence since October, what was the change that came in before the report was tabled at the end of last year? Clearly the reform process comes after whatever changed that resulted in that violence stopping.

Ms Davidson: I understand that there were things that we were able to put in place relatively quickly once we received that report, and that has helped.

MR COCKS: And what were those?

Ms Davidson: I think Katie McKenzie can speak in more detail to some of the first things that were implemented.

Ms McKenzie: Yes, and I do want to acknowledge that the report came out in November. We were already a significant way into our reform program before November. We had an action plan and that outlined a range of interventions that were already taking place. That was about intervening before flashpoints of aggression. That is through safe wards, through the use of DASA and through one-to-one engagement when we recognise that people are escalating. So all of those things were in place and we strengthened and continued on the reform journey when the Dhulwa independent inquiry came out.

MS KIKKERT: The Dhulwa corrections review concurred with the 2022 Healthy Prison Review that a high proportion of detainees were reporting that general and specialist medical services were difficult to obtain and that this was especially the case for Aboriginal and Torres Strait Islander detainees. They put forward a number of recommendations, such as an accessible female-only space to be implemented to allow women safe access to healthcare services, regular audits be conducted into trauma aware practices and cultural safety and a review into release and post-release protocols for health care and medications to ensure a supported transition. What is Justice Health doing to address these recommendations?

Ms Davidson: Before I pass to Katie McKenzie, who can talk in more detail to how we are addressing the recommendations, I would like to note that, in providing health care to people within that environment, there are constraints that they have to work within that they do not necessarily have in the same way in a community health centre. The amount of space available and the ability to move people in and out through waiting areas and getting them to and from appointments is somewhat constrained by being in a corrections facility and whether there are people available to walk them to and from and who can be in a waiting room with other people at the same time. But Katie McKenzie can speak in more detail to how we are meeting the recommendations.

Ms McKenzie: Absolutely. Questions regarding facilities at Hume Health Centre would need to be directed to Justice and Community Safety. We continue to work with them on what our needs are. We have implemented a number of

recommendations. I know you asked particularly about the Healthy Prisons Review, but one of the things that we have focused on throughout the year with our partners in Corrections and also with Winnunga is taking stock of all the recommendations that have sat open. In the space of the Auditor-General report, we have closed 17 of the 18 recommendations that were accepted and, for CHS, we do not have a recommendation within the Healthy Prisons Review for AMC. We do not have a recommendation open anymore.

In terms of release planning, you are absolutely right that that is a critical point of transition for detainees as they move into the community. We have started looking at processes of handover of information, and we hope next year to introduce a GP clinic that is specifically going to ensure people can come back within the first couple of days so that there is no loss to any system at all. So here are active conservations, and that is one of the actions in the Detainee Health and Wellbeing Strategy Action Plan.

MRS KIKKERT: Just to clarify, Katie, when you say "closed recommendations" does that mean that they are completed?

Ms McKenzie: They are completed. The ones that sat with CHS and by CHS Justice Health.

MRS KIKKERT: Staff of Winnunga and people in custody advised a review team that the major delay in accessing Winnunga is not so much what you mentioned, Minister, in terms of waiting because of different detainees in the same room, but that the referral process from Justice Health could be quite lengthy. Could you give us some insight into what that process looks like and what might be causing it to take a long time?

Ms Davidson: Katie McKenzie will be able to talk through the referral process to Winnunga. I would note that we are in a fairly unique position in the ACT in that people do have a choice of who they can go to for their health care. I think that is a really important aspect of giving people agency over their own health decisions and hopefully getting better outcomes for them through that. Not everyone is going to want to go to Winnunga. Not everyone is going to want to go to Justice Health. To have the choice is quite a helpful thing. The referral process, though, I think Katie can speak to.

Ms McKenzie: Yes, thank you. One of the active conservations that we have with Winnunga is about how we can streamline their referral process. We do actually measure it. I just cannot quite get the data to hand. If I am able to get it to hand before we finish, I would be happy to let you know about the time frames involved in that. I will just wait for somebody to send it. We are measuring it, we do table it and we do discuss it with Winnunga—which are some really positive steps from where we were last year.

MRS KIKKERT: The review team found that a majority of Aboriginal and Torres Strait Islander people in custody viewed the Crisis Support Unit as appalling and that they were reluctant to use it even when experiencing significant mental health issues. The 2022 Healthy Prison Review found something similar, saying that it was an "austere environment" and "more likely to escalate and trigger challenging behaviour

rather than provide a sensory environment conducive to recovery and de-escalation of challenging behaviours". This finding was from a year ago now. What has been done to respond to these findings?

Ms Davidson: Before Katie speaks to what is being done about the Crisis Support Unit, one of the key things to be clear about is that if it is a crisis support unit you do not want people in there for long periods of time where they are in a more restrictive environment than they would be elsewhere in the AMC. It is not something that you would want to have to transfer people into unless it was clinically necessary. But Katie can talk a bit more about care for people in the Crisis Support Unit and how that has changed.

Ms McKenzie: From a CHS perspective our focus this year has been on Dhulwa. Dhulwa has an exceedingly important role in accepting people from the AMC who require therapeutic input. In the reform program Dhulwa one of our strong commitments is to make sure that that pathway is robust and flowing. That is very clearly identified in our model of care that is out for consultation at the moment.

In terms of environmental changes to the CSU, as I said, that would need to be directed to the JACS Directorate. We are really committed to continuing to work with them, and I am aware that they have an environmental architect who is going to start looking at these areas.

I can also come back to those figures for Winnunga. For the month of October, 13 consumers asked to be referred to Winnunga. All 13 have been referred. Six are being reviewed at the moment and seven are pending review by Winnunga.

MRS KIKKERT: Thank you. Minister, you mentioned the expansion of the health hub at AMC. Does the design of that health hub fall under your responsibility or is it more JACS?

Ms Davidson: That would be more of a JACS area in terms of managing the physical spaces at the AMC. But if there were to be work done to improve the physical spaces I would expect that Justice Health and Winnunga would both want to have quite a bit of input into what that might look like.

MRS KIKKERT: What has been your input to Mr Gentleman in terms of expanding the health hub there?

Ms Davidson: He is aware that this is an issue that we need to continue discussing and working on.

MRS KIKKERT: What have been those issues?

Ms Davidson: You were just referring to the Healthy Prison review and some of the recommendations from the Auditor-General's report as well. Some of those recommendations related to the constraints of space that exist out at the existing AMC.

MRS KIKKERT: Are you actively advocating for more space in the health hub at AMC, in terms of more facilities, more room?

Ms Davidson: There would be a number of steps that we would need to go through to better understand how we can best use the spaces that are available at the AMC. That decision would need to be taken by multiple ministers working together.

MRS KIKKERT: But you do know that currently the facility does not meet demand. I am asking: are you advocating to Minister Gentleman in terms of expanding that facility to make more space and more rooms for more care for the detainees there?

Ms Davidson: It is also about how we use the spaces that we have.

MRS KIKKERT: It is just a simple yes or no.

Ms Davidson: It is also about how we use the spaces that we have. There may be ways in which corrections can work together with Winnunga and Justice Health to make better use of the spaces that they have, in addition to better understanding what needs to be prioritised in terms of any additional spaces that might be needed in the future.

MRS KIKKERT: So that is a no. Thank you, Minister.

THE CHAIR: What supports are available for people who are living with a disability and also suffering mental health issues? How does the government approach this? I guess it can be quite a difficult matter to navigate around, and it is not widely discussed, as I understand it.

Ms Davidson: For many years now, a fairly significant amount of work has been done by the peaks in the community sector to advocate for better support for people who have co-occurring physical and mental health conditions. It was something that I worked on before on I came into this place. We continue to get some really helpful feedback and input from organisations like MHCN, MHCC, the Women's Centre and others around what can be done. The Disability Health Strategy, I think, will help somewhat in better understanding how we can provide supports to people who have multiple co-occurring conditions.

Work also needs to be done on how we can better get some of the commonwealth regulated and subsidised services working well with services delivered within CHS, within the ACT system, to make sure that we are meeting the totality of people's needs. We need to ensure that we are looking through that social model lens, seeing the whole person and not just a single clinical diagnosis, which might be the part that we are treating in that very moment.

THE CHAIR: What are some of the commonwealth services you mentioned and how can that help provide the supports?

Ms Davidson: Let's say you have someone who is dealing with a condition like rheumatoid arthritis and they have depression at the same time. There are a significant number of people in Canberra who have those two co-occurring conditions. People have talked to me about seeing their rheumatologist and their rheumatologist says, "You really need to reduce the amount of physical activity that you are doing because

it is aggravating and inflaming your physical condition." At the same time, they are talking to their psychologist, who is saying, "Actually, if you go for a walk every day in the fresh air that will really help with your depression." That is in addition to the medications they might be taking for the two conditions. The person is stuck in the middle, thinking, "Which condition would I like to aggravate today?" That was the way it was described to me by people who were actually experiencing it.

If we can find ways to better coordinate and support care for people in those situations we might find that they end up with fewer hospital admissions and better outcomes and better ability to achieve the other things they want to do in their life because they are able to manage both conditions at once, instead of having that fragmentation. If we are talking about rheumatologists and psychologists, quite often we are talking about people who are seeing someone in the private system. That is a commonwealth subsidised area, but if it is not working well then those people can end up in our hospitals, where they really did not want to be. So it is in our entire community's best interests to make sure that we are finding ways to reduce that fragmentation and to better integrate people's health care.

THE CHAIR: I guess one of the tricky areas would be trying to provide supports or supporting the service providers out there who might provide support for those people who have a neurological disorder but also mental health issues. It might be very hard to identify what is being done in that space. Is the government working with anyone to ensure that the right supports are out there?

Ms Davidson: Are you talking about co-occurring—

THE CHAIR: Asperger's.

Ms Davidson: Autism and depression.

THE CHAIR: Autism but also suffering from a mental health issue. They are obviously very hard to identify in a lot of circumstances. What is the government doing to work with service providers to ensure that the right supports are given to those people?

Ms Davidson: That is a really important area that needs to be worked on. The recent parliamentary inquiry into services and supports for people with ADHD highlighted that just navigating the bureaucracy of the system itself can be quite traumatic for people and increase their levels of anxiety and stress, which is not great for their mental wellbeing. Absolutely, there are things that could be done at both the commonwealth and the state level to make it easier for people to do that. I am very keen to work with commonwealth ministers on how we can get those systems working well together. We have an opportunity at the moment where we could make a real difference for people and get better outcomes for them. I would very much like to be able to do that.

THE CHAIR: When will that commence, do you think?

Ms Davidson: Some of these will relate to how we implement the recommendations of the NDIS review, which has yet to go to national cabinet and be publicly released.

Hopefully, that will not be too far away now. There are also the disability royal commission recommendations and that AHD inquiry report that came out about a week ago, as well as some of the things we have learned from the ACT's Disability Strategy consultation and the Disability Health Strategy consultation about access to health services.

THE CHAIR: Is it too late to include something in the new Disability Strategy that is due to be released next month, as I understand? Is it too late to include something in that or could this be additional?

Ms Davidson: The ACT Disability Strategy is not going to be the only place where we can make improvements. There are also going to have to be cross-jurisdictional government responses to the NDIS review recommendations, which is how a lot of people who have chronic long-term mental health disability and psychosocial disability have needed to access services for quite some time now.

We know from the NDIS review that there are things that could be done better to help people achieve better outcomes. We would like to do those, but that is going to require commonwealth and states to work together. What is really important is that all of the states and the commonwealth are doing this in a very coordinated way so that we do not end up with a postcode lottery for psychosocial mental health supports.

MR COCKS: Just a quick clarification. You mentioned a couple of particular specialities. Rheumatologists, I think, was one and you suggested that the way people would access that is through commonwealth reimbursed medical services, assumingly under Medicare. Does the ACT not provide those services for people through the public system?

Ms Davidson: You are really highlighting the diversity of ways in which people access health services.

MR COCKS: No. I am asking a question. It sounded like you were suggesting that they cannot currently. Is that correct?

Ms Davidson: No, that is not correct. There are people who are accessing services through our public health system as well. The example that I gave to you was of a person who was participating in a focus group who talked specifically about accessing a private rheumatologist and a private psychologist and their advice conflicting about the two different health conditions the person was having treated. It is not an uncommon occurrence for that sort of thing to happen when you have co-occurring physical and mental health conditions.

MR COCKS: Thank you.

MR PETTERSSON: Minister, I was hoping the committee could get an update on the development of the action plan for the Mental Health Workforce Strategy?

Ms Davidson: Yes. Before I pass to Dr Moore to talk about that piece of work, we have been doing a lot of work to make sure that this also lines up with the development of the draft National Mental Health Workforce Strategy, because we

know that the problems that we are experiencing here are not unique to the ACT. In fact, they are global issues, such as getting enough people in our healthcare workforce and then making sure they are well-supported and able to stay to do their work. I will pass to Dr Moore, who can talk about where that is up to now.

Dr Moore: Thank you, Minister. As the minister said, it is very much about looking at how we can retain the staff that we have; looking at alternative workforces, such as a peer workforce, which are not only a good workforce but also culture changers; and looking to universities to increase the range of professionals that we can get within the workforce. We have done a fair bit of consultation on the action plan and we have the first one-year work plan, which is currently being considered by government. We will let you have it as soon as we can.

MR PETTERSSON: I guess it is more a question for you, Minister: can you give any indication as to when we can expect to see this publicly available?

Ms Davidson: It is stepping through the process at the moment to make sure that we have completed everything that needs to be done. I know that it is not very far off. I expect that, as soon as it is ready, we will be making announcements about that, but I could not give you an exact date right now.

MR PETTERSSON: That is fair enough. I am just trying to get a sense of timing. Are we thinking this year, early next year or some point next year?

Ms Davidson: I could not tell you, off the top of my head, when it is going through cabinet, but I know that it is soon.

MR PETTERSSON: Thank you. Was there any funding in the most recent budget to support and expand the ACT mental health workforce?

Ms Davidson: Yes. There were a number of budget initiatives that went to better supporting our workforce. I could pass to Mr Peffer, who could talk more generally about our health workforce and what was in the budget for that. Having things like lived experience directors being employed, and having funding there for better integration of mental health and drug and alcohol services, are particularly important for supporting the workforce, and the child and youth mental health network as well, to improve youth mental health. Mr Peffer can probably speak in more general terms about budget initiatives that support the workforce in health.

MR PETTERSSON: To narrow it down a bit: to support and expand the mental health workforce.

Ms Davidson: I guess a number of those things that I was just talking about do mean additional FTE being employed to do that work. I do not know if you want to focus particularly on youth mental health or drug and alcohol and mental health integration.

MR PETTERSSON: I am just trying to separate the funding for a new position, as opposed to the funding to improve the system to get more people into the workforce.

Ms Davidson: Like improving pay and working conditions; is that what you are

looking for?

MR PETTERSSON: No. To give a different example, when it comes to the Disability Strategy, you need to fund that strategy to put it into action. I get that the action plan for the workforce strategy is not yet finalised, but I am wondering: was there new money in the budget to start some of the things that we might see in the action plan to get more people into the mental health workforce?

Ms Davidson: That sounds like it might be a question better answered by Dr Moore, as to how we resource that workforce strategy implementation. That is what you are looking for?

MR PETTERSSON: Yes.

Ms Davidson: Yes.

Dr Moore: Thank you. Yes, there were some budget initiatives. As the minister has said, what we had funded in the last budget to help with workforce was that coordination piece, so that drug and alcohol and mental health services align. That is where the support for the youth mental health services aligns, and support to implement or coordinate the strategy. We have also had the lived experience director and a second lived experience position to help drive the lived experience strategy within that Mental Health Workforce Strategy.

MR PETTERSSON: Thank you. You may need to take this one on notice. How many funded positions are there at Canberra Health Services in the mental health areas of the health service and what is the vacancy rate of those positions?

Ms Davidson: That sounds like it is probably a question for Katie. Do you have the numbers?

Ms McKenzie: I do. I anticipated that you might ask me this. Our current budgeted FTE is 951.7. We have an actual FTE of 840, so we have a variance of 111 FTE. That is quite stable, and about 11 per cent of our workforce. We do backfill some of that with agency staff, particularly for psychiatrists and nursing.

MR PETTERSSON: All right. Thank you.

MR COCKS: We discussed this strategy quite extensively last year, particularly focusing on the lack of detail in the strategy. When asked about delays, you blamed the delay on the federal strategy, and similarly suggested that the content of what you would actually do would be to provide an action plan. Dr Moore, I believe it was you who said that that action plan would be with the minister in April of this year. The annual report indicates that, as at June, a draft seemed to still be being circulated for stakeholder comment. When was the document provided to the minister?

Ms Davidson: It is very worthwhile, when you are getting feedback through consultation, to take the time to incorporate that feedback into your draft plan and then circulate it and go back to people and check that you are getting it right.

MR COCKS: Minister, I appreciate the benefits of good consultation. What I am asking about is simply when the plan was provided to you, given that an April target date was provided to this committee last year.

Ms Davidson: The plan has gone back and forth a number of times. I can tell you that it is close to being finalised now. I have seen a number of iterations of the draft over a period of time, so which version would you like?

MR COCKS: Perhaps you could tell me when it first went to your office.

Ms Davidson: I will take on notice on what date I first saw the draft plan, but it has gone back and forth a number of times and had extensive consultation with stakeholders as well.

MR COCKS: When was the need for an action plan first raised with your office?

Ms Davidson: I would have to take on notice when we first discussed the action plan.

MR COCKS: Was it before or after last year's hearings?

Ms Davidson: I expect that if we were discussing it at last year's hearings it would have been well before.

MR COCKS: The commonwealth published their Mental Health Workforce Strategy over a month ago now. Unless I have counted wrongly, that strategy manages to include over 70 different actions. Can you tell me: what is the ACT's role in supporting that one?

Ms Davidson: Dr Moore can probably speak in more detail about how the ACT strategy fits in with the national one.

Dr Moore: Thank you, Minister. I might pass to my colleague Cheryl Garrett, who was our representative. The ACT was intimately involved in the development of the plan and eagerly awaited it.

Ms Garrett: Thank you. I acknowledge the privilege statement and accept it. We had around six meetings of the National Mental Health Workforce Strategy group, with all states and territories represented. When we look at the pillars that are in the national strategy, they align quite neatly with the direction of our framework for change and the draft action plan that is sitting with the minister.

In terms of our contribution, the commonwealth has set those four pillars on an annual basis. The first pillar that is being focused on by that working group is the attract and retain pillar. We will be contributing to that in terms of where the identified priority workforce groups are. Those are identified in the national agreement. They are things like allied health workers and others that are listed in the national agreement.

MR COCKS: You will be contributing by seeing where they are?

Ms Garrett: No. They have been identified in the national agreement. It is about how

each jurisdiction will contribute, what activities we will do to support those priority workforce groups.

MR COCKS: I guess that is what I am asking: what activities will the ACT be doing to support this strategy and those actions?

Ms Davidson: You are asking for a preview of the plan that is yet to be published.

MR COCKS: No; I am asking what the ACT has committed to do to support the commonwealth plan.

Ms Davidson: That would be part of our own plan that has not yet been published and is still going through the process. Do not worry; you will get to see it soon.

MR COCKS: Let me ask, then: why is it that, a year after we discussed this last, when we had only a plan on a page, five years after your predecessor and current leader, as Minister for Mental Health, articulated the need for this work, and roughly 18 years after the first reports to the ACT government showing that we needed to address these issues, we are still waiting for concrete actions to address the mental health workforce problems in the ACT?

Ms Davidson: As you pointed out a few moments ago, the national strategy was only published about a month ago and it has something like 70 different actions in it.

MR COCKS: That is the most recent one.

Ms Davidson: We have a very diverse system where some services and supports are delivered by parts of the workforce that are more directly impacted by what the commonwealth is doing and others are more directly impacted by what the ACT is doing. It is very important, if we want a health system that is able to deliver good outcomes while attracting, retaining and developing the skills of our mental health workforce, that both the national strategy and the ACT strategy work well together. No single strategy will solve all of those problems on its own, and we have been engaging with the commonwealth all the way through to make sure that what we are doing is working well together.

MR COCKS: I might return to the question around mental health patients going missing or absconding from care. I want to start by clarifying one of the points you made in the last response. I was asking about the number of patients and occasions when patients have absconded or gone missing. You were very clear in your response that you were only referring to patients who were uncontactable during approved leave. Are there any other occasions when any patient has absconded from care or gone missing in any other way?

Ms Davidson: I was talking about a person who is on approved leave and we cannot contact them. That was the number that I was talking about there.

MR COCKS: Yes, and I am asking if any patients have gone missing or absconded in any other circumstance.

Ms Davidson: Someone who has absconded who was not on approved leave; is that what you are asking about?

MR COCKS: Exactly.

Ms Davidson: I might need to take on notice how many times that has happened in the 2022-23 financial year.

MR COCKS: Thank you; that would be appreciated. What is the procedure when a patient absconds or goes missing, and is it the same across all mental health facilities?

Ms Davidson: It will also depend on whether the person was a section 309 patient, I believe. Katie, is that a question for you?

Ms McKenzie: It is, yes. We do have a policy in our process that outlines what we do. Our procedure is called "AWOL", which is absent without leave. The very important point being made by the minister is that, for the majority of people who are absent without leave, it is on returning from leave. There are a couple of people in that who will have left without being on approved leave. The actual detail of that will need to be taken on notice.

Our response in those spaces is a dual response—to try and contact the consumer, firstly, because it is actually about encouraging them to return, and to work with the police to try and locate the consumer.

MR COCKS: At what stage or under what conditions are police contacted?

Ms McKenzie: I am sorry, I do not understand; under what conditions?

MR COCKS: What is the trigger for contacting the police? Is it simply time based or is there a risk factor involved in decisions to contact the police?

Ms McKenzie: No, we contact the police for everybody. It is one of our initial actions.

MR COCKS: How do you assess risk to the community when considering requests for leave from admitted care?

Ms McKenzie: That is a detailed clinical decision that is made by the multidisciplinary team, led by the psychiatrist. I am not able to give the detail behind what it is that they do, except to say that a consultant psychiatrist has undertaken many years of training to make risk assessments. It is a clinically informed decision and all of our care is psychiatry governed.

MR COCKS: If a patient has been admitted from the justice system, after being found not guilty of a crime based on mental impairment, does that history continue to be considered when assessing whether to grant leave or is it only the current clinical state of the patient?

Ms McKenzie: There are a range of tools. This is a very detailed clinical decision that is made by exceedingly trained and expert people.

MR COCKS: Would they take that piece of information into account?

Ms McKenzie: I could not answer that. There are a range of clinical tools that are considered. There is a panel; there are a range of people—

MR COCKS: Is there anyone else in the room who could answer the question?

Mr Peffer: We would need to take that on notice and provide you with some written advice about the sort of considerations that our—

MR COCKS: The Chief Psychiatrist could not provide advice on this question?

Ms Davidson: We have had our Chief Psychiatrist come and give you a brief and to talk through the details of how leave works and how those decisions are made.

MR COCKS: In fact, no, you have not. The briefing that we had was around a specific set of circumstances where the Chief Psychiatrist could not provide a lot of information. I am asking the general question, and it seems like that would be the appropriate person to provide the advice.

Ms Davidson: Yes, we can arrange for you to have another briefing so that you can ask the questions that you need to about how—

MR COCKS: Can't someone in the room provide advice today?

Ms Davidson: What is it that you are looking for? Do you want, step by step, what is the process by which the decision gets made?

MR COCKS: No, I am asking whether the history of a patient admitted from the justice system, after being found not guilty based on mental impairment, is considered in that process of granting leave or whether it is only the current clinical state of the patient.

Ms Davidson: Dr Arya might be able to speak in more detail as to whether that is taken into account.

Dr Arya: Any risk assessment has to consider any and every information about any potential risk that the person may present. That is a longitudinal assessment; that is never a cross-sectional assessment. As part of risk assessment, the psychiatrist or a mental clinician would be considering all possible information that is available on that person that is clinically relevant.

MR COCKS: What factors do you consider when transferring a patient from the secure mental health unit to the transitional unit in Bruce? For example, do you also consider risk to the community and a patient's history there?

Ms Davidson: That would be a clinical decision that would be made by the team involved. Dr Arya might be able to talk through the process.

Dr Arya: Yes, certainly. Any transition decision—and this is a transition point—considers the psychopathology or the symptoms that the person may be experiencing, and the kind of risk that psychopathology may present to the person or to anyone else, including the community, and that would determine whether that transition can occur or not.

MR COCKS: Is information about a patient's history in the justice system available to all treating clinicians and nurses for the duration of their stay as an admitted patient?

Dr Arya: The information on psychopathology, the symptoms and the signs that the person may be experiencing would be available to clinicians.

MR COCKS: What about their history in the justice system? If, for example, someone had been admitted following an extremely violent incident, would that be available to all treaters?

Dr Arya: Yes.

MRS KIKKERT: Ms McKenzie, you said that when a patient absconds you contact police. Do they report back to you on the status of that patient?

Ms McKenzie: In the vast majority of incidents, the patient is returned to where they have absconded from.

MRS KIKKERT: The vast majority?

Ms McKenzie: Yes. I cannot give you the exact numbers. We have taken that on notice. For those that have not returned to where they have absconded from, we do keep in contact with the police about what is happening.

MS CLAY: Minister, we now have a Safe Haven operating in Belconnen, and I am really pleased to see it operating there. It is still fairly new; can you let me know what sorts of services it is providing and what sorts of people it is helping?

Ms Davidson: Yes, absolutely. One of the great things about the Safe Haven is that the feedback we are getting is that there are people in the community who are finding it is helping them in such a way that they feel comfortable going back there multiple times. If you were to ask people about going to the emergency department when they are experiencing distress, they probably would not feel quite so keen about wanting to go back to the emergency department multiple times. The Safe Haven is genuinely a place where people feel more comfortable going in and talking to someone about how they are feeling and what they can do about it.

Because of the success that it has been having, that is why we are moving ahead with the plans for the second Safe Haven, on the Canberra Hospital campus. The co-design team for the original Safe Haven in Belconnen initially said, "Let's have two: one on the hospital campus and one in the community." We are finding that it is so successful that we are looking at how many more Safe Havens we need to meet demand in the community in future years and how that might impact on people's long-term mental

health conditions.

For some people who are going into the Safe Haven, it is not just a one-off situation or a distress situation; some of the people who go in there do have chronic mental health conditions. They are finding that it reduces their need to get, for example, additional psychologist appointments through their NDIS plan, which can be hard to do at short notice, access other support services or end up in inpatient care which could have been avoided if they had been able to engage with the right service earlier. If we can do that, we will see better outcomes longer term and more people being able to stay at home in the community and receive their ongoing care there.

MS CLAY: Are we finding that those drop-in services are a good diversion from the emergency department and other services?

Ms Davidson: Yes. We are also finding that there is a broad diversity of people in the community who are finding this a useful service. Veterans have talked to me about how useful they find the service; university students have talked to me about good experiences that they have had accessing the service. I refer also to people in the LGBTIQ community. We are talking about a really diverse range of people who are accessing these services and finding that it is helping them.

That really speaks to the value of having services with peer workers who themselves are representative of the diversity of people in our broader community who might need to access those things. That is a really good, positive sign.

MS CLAY: That is great. Do they have secure funding in Belconnen?

Ms Davidson: The Safe Haven in Belconnen has been doing very well. Making sure that we continue these services into the future means evaluating, because it is a relatively new service, how it has been going and getting a better understanding of whether there are things we might need to change about that service, whether it is resourced enough to meet demand and where else we might need additional services in future.

MS CLAY: Are you using that information to help scope the budget for the next Safe Haven, the one that will be co-located at the hospital?

Ms Davidson: Yes, absolutely. The things that we have learned from the Safe Haven in Belconnen are absolutely being taken into account in planning for the Safe Haven at the Canberra Hospital campus. We also understand and expect that there will be a slightly different demographic and different clinical needs that might present at a Safe Haven on a hospital campus compared to a Safe Haven in the community.

We are also taking into account things that we are learning from similar kinds of services in other parts of Australia that have done this. All of us are doing things that are relatively new in Australia, so being able to share that knowledge about what is happening in other cities has been really helpful for us in thinking through how we might do it differently in the ACT.

MS CLAY: That is great. What sort of data are you measuring? Are you measuring

whether this is affecting the number of people who are in crisis, whether it is affecting diversion? How do you measure success on something like this?

Ms Davidson: This is one of the benefits of thinking about things from the perspective of being a disability minister and thinking about what happens for people with psychosocial disability, as well as people who might be in situational distress or people who might otherwise have presented to the emergency department. Yes, there will be some benefits in reducing the number of people who present to an emergency department at a more acute stage of crisis, because if you can get help earlier and you feel comfortable doing so, hopefully, you will seek help before you become that unwell.

Some people are finding that visiting a Safe Haven maybe six or seven times over the course of six to 12 months actually helps them to get back on track for their chronic mental health condition. Safe Havens can also pick up what might be an emerging issue. If they have not seen someone for quite some time and the person starts visiting them again regularly, that can help them to support the person to engage with the kind of care that gets them back on track. There are a number of different parts of our health and social services system for which our Safe Havens are creating benefit.

MR COCKS: Minister, over a year ago now, a man was violently killed in the Adult Mental Health Unit. In the immediate aftermath of that event, we asked a number of questions about what had gone wrong. You declined to provide any salient information about the event, both in briefings and in the Assembly, but indicated reviews were underway and that further information would be provided in due course. What is the current status of those reviews?

Ms Davidson: I would note that we are talking about a matter that is before the courts. We are talking about someone who was charged with a criminal offence, so what I am able to say while that process is ongoing is more limited, and we discussed that with you in briefings at the time of the incident.

MR COCKS: I understand. What I am asking about now is the current status of the reviews that you said were happening into both the circumstances within the health service and the general clinical settings. What is the status of those reviews?

Ms Davidson: Katie McKenzie will be able to talk more about the internal reviews.

Ms McKenzie: I can give you an update on the internal review. We did an internal review with an independent chair. We invited a very experienced psychiatrist from a Melbourne local health district, who has a lot of experience in terms of clinical governance. That review made three recommendations. One was related to CCTV, one was to implement training to ensure a shared understanding across a multidisciplinary team about ISBAR handover, and one was to implement the allocation of staff to the floor as well as allocation to tasks during a shift.

All three recommendations are due at the end of this year. Two are on track to be delivered within that time frame. One has a very slight delay because we need to do broader consultation about CCTV in mental health settings. We are tracking well. In terms of other reviews, there is still a major incident open with WorkSafe regarding

this incident, and neither the coronial nor the criminal process has occurred yet.

MR COCKS: When was the review that you have just spoken about delivered, and was it provided to the minister?

Ms McKenzie: I can give you the date that it was delivered. I will have to take on notice whether we shared it. It is an internal review.

Ms Davidson: Yes, I do remember reading the pages when they came through.

Ms McKenzie: If you bear with me for one moment, I have a copy and I can give you the date.

Ms Davidson: I could not tell you exactly when they came through.

Ms McKenzie: It was endorsed on the 2nd. The review panel delivered on 24 May, and it was endorsed at executive level on the 2nd of the 6th. So we moved quite quickly to review that incident.

MR COCKS: Is there a reason that there does not seem to have been any public update around that, given your commitment to keep the Assembly, at the very least, updated?

Ms Davidson: There is still the coronial inquest that will need to happen. I expect that there will also be some useful things to learn from the coroner's report. But that process is still ongoing, as well as the criminal process.

MR COCKS: The other thing that you relied on in declining to answer questions was the protected information provisions of the Health Act 1993. You have invoked those again recently in relation to the incident that led to the stabbing of students at the ANU by a person who had been released on leave from the Bruce facility. Those protected information provisions apply only to information about the person that is disclosed to or obtained by an information holder because of the exercise of a function under the act. What was the function under the act that applied in each of those instances?

Ms Davidson: I did take some advice from GSO about what we can say publicly when there is media reporting about a named individual and their mental health treatment. It is really important to ensure that, when we are talking about someone whose name is publicly known, whose photo has been appearing in the paper, we are respectful of the law in what we disclose about their personal health records. That person will be continuing to receive treatment, and we need to make sure that we are not actually breaching the law in what we say publicly, especially if there is a criminal charge that is being addressed.

MR COCKS: So is that legal advice?

Ms Davidson: Yes, I received legal advice.

MR COCKS: Is that something you can share with the committee on notice?

Ms Davidson: Yes, I believe you have asked me questions without notice about that in the chamber, and I have answered them already. But I can check the *Hansard* and send it to you again.

MR COCKS: Do you know what needs to change in the act to enable public interest disclosure of important information when things go wrong in the health system?

Ms Davidson: If you are talking about the ANU incident, I think it would be wise to allow the review process that has already started to provide its report on what needs to change before we go ahead and start making those changes.

MR COCKS: But you have said that you will not release those reports in full.

Ms Davidson: I will be releasing a report that goes to what kind of systemic changes might need to be made, but I will not be releasing a person's private health records.

THE CHAIR: On behalf of the committee, we would like to thank the minister and officials for your attendance today. We would also like to thank broadcasting and Hansard for the amazing work that you do recording these hearings. If you have taken any questions on notice, please provide your answers—

Mr Peffer: Chair, can I just correct one thing that I said to the committee?

MR MILLIGAN: Yes, you certainly can.

Mr Peffer: It has been brought to my attention that there was an incident reported from Dhulwa in August 2023—this year. It did not lead to an injury or any time off work. Nonetheless I needed to clarify that. There was no injury, but there was an incident, nonetheless.

MRS KIKKERT: Did that involve staff and a patient?

Mr Peffer: It did.

MRS KIKKERT: Both?

Mr Peffer: Yes.

MRS KIKKERT: Physical violence?

Mr Peffer: Yes.

MRS KIKKERT: Between the staff and the patient?

Mr Peffer: It was an incident that occurred that led to no injury, but potentially could have.

MRS KIKKERT: It was an incident between staff and a patient of physical violence?

Mr Peffer: That is correct.

MRS KIKKERT: Did a guard attempt to intervene?

Mr Peffer: I do not have that information.

MRS KIKKERT: Could you take that on notice, please?

Mr Peffer: I could take that on notice, yes.

MR MILLIGAN: Thank you, Mrs Kikkert, and thank you, officials. If you have taken any questions on notice, could you please provide your answers to those questions to the committee secretary within five business days from the uncorrected proof *Hansard* being made available? If any members wish to ask questions on notice, please put them on the parliamentary portal as soon as possible, and no later than 15 business days after the hearing. This hearing is now adjourned.

The committee adjourned at 2.46 pm.